

# CONFIDENTIAL PATIENT CASE HISTORY



## WELCOME TO OUR OFFICE!

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Marital Status: S / M / D / W  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ How Many Children (Ages)?: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Who Referred You To Us?: \_\_\_\_\_  
How Else Did You Hear About Us?: \_\_\_\_\_

### CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?: \_\_\_\_\_  
How long have you had this condition?: \_\_\_\_\_  
Have you had this or similar conditions in the past?: \_\_\_\_\_  
What do you think caused this condition?: \_\_\_\_\_  
What position(s), if any, make it feel worse?: \_\_\_\_\_  
What position(s), if any, make it feel better?: \_\_\_\_\_  
Over time, is this condition:  Improving  Unchanged  Getting Worse?  
Is this condition interfering with your:  Work  Sleep  Daily Routine Other: \_\_\_\_\_  
Have you sought advice or treatment from other doctors or therapists for **this** condition?  Yes  No  
If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

_____	_____	_____
Name	Date of visit	Diagnosis
_____	_____	_____
Name	Date of visit	Diagnosis

Describe any treatment you have had for **this** condition (include medication dosage and frequency?): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

May we communicate our findings on your current health condition to the above provider(s)?  Yes  No

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.

Primary Complaint:

1) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

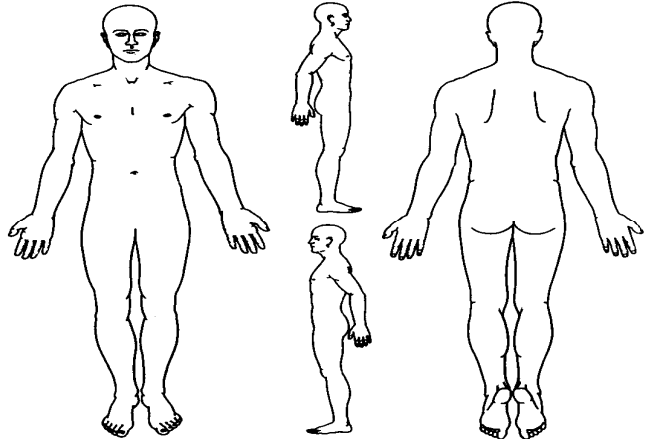
Additional Complaints:

2) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

3) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

4) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

5) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10



## PREVIOUS CONDITIONS

Days Lost From Work: \_\_\_\_\_ Date of Last Physical Examination: \_\_\_\_\_

Have you sought care for another health condition in the past year?  Yes  No Past 2 years?  Yes  No

If yes, what condition other than your primary complaint?: \_\_\_\_\_

Was treatment administered?  Yes  No Describe: \_\_\_\_\_

Do you take medications?  Yes  No List Dosage, Frequency and Reason: \_\_\_\_\_

Any prior hospitalizations or surgery?  Yes  No Describe with dates: \_\_\_\_\_

Have you been in an auto accident or had any other personal injury?  Yes  No Describe: \_\_\_\_\_

## CHIROPRACTIC HISTORY

Previous Chiropractic care?  Yes  No If yes, Doctor's name: \_\_\_\_\_

Date of last chiropractic visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last chiropractic X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for care: \_\_\_\_\_ How long were you under care?: \_\_\_\_\_

Were you satisfied with the previous chiropractic care you received?  Yes  No

Are other family members under chiropractic care?  Yes  No Who?: \_\_\_\_\_

Are you open to looking at new ideas in health and wellness?  Yes  No

## SOCIAL HISTORY

Height: \_\_\_\_ft. \_\_\_\_in. Current Weight: \_\_\_\_\_ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work:  Heavy  Moderate  Light Hours per day: \_\_\_\_\_

Physical Work:  Heavy  Moderate  Light Hours per day: \_\_\_\_\_

Exercise:  Heavy  Moderate  Light Hours per week: \_\_\_\_\_ Type: \_\_\_\_\_

Smoking:  Never  Currently  Previously Packs/day: \_\_\_\_\_, Pack/week: \_\_\_\_\_ How long?: \_\_\_\_\_

Alcohol: Beer/week: \_\_\_\_\_, Liquor/week: \_\_\_\_\_, Wine/week: \_\_\_\_\_ How long?: \_\_\_\_\_

Caffeine: Cups/day: \_\_\_\_\_ How long?: \_\_\_\_\_ Aspirin: No./day: \_\_\_\_\_ How long?: \_\_\_\_\_

# CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## REVIEW OF SYSTEMS

### GENERAL

	Now	Past
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>

### SKIN

Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>

### HEAD & EYES

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

### EARS

Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>

### NOSE

Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>

### MOUTH

Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>

### THROAT

Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>

### NECK

Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>

### BREASTS

	Now	Past
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>

### RESPIRATORY

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Inhalant exposure	<input type="checkbox"/>	<input type="checkbox"/>

### CARDIOVASCULAR

Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain, Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>

### BLOOD

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>
Red Spots	<input type="checkbox"/>	<input type="checkbox"/>

### GASTROINTESTINAL

Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Irreg. Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Black Stools	<input type="checkbox"/>	<input type="checkbox"/>

### GENITOURINARY

Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Stones	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>

### GENITOURINARY

	Now	Past
Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Spotting	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Painful Menses	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

### NEUROLOGICAL

Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>

### ENDOCRINE

Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

### IMMUNIZATION/VACCINATION

DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

### PSYCHIATRIC

Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Troubles Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

### MUSCULOSKELETAL

Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

### PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Tumor	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>
Parasites	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>
Polio	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Gout	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Bladder Trouble	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>
Dysentery	<input type="checkbox"/>

### ALLERGIES

List known allergies below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If Female,  
Are You Pregnant?**

Yes  
 No

# CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **FAMILY HISTORY** - List any of the diseases listed previously which run in your family

<b>Relative</b>	<b>Age if Living</b>	<b>Age at Death</b>	<b>Cause of Death</b>	<b>State of Health</b>	<b>Illnesses (if any)</b>
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status:  Poor  Fair  Good  Excellent

Children's ages and health status: \_\_\_\_\_

## **INSURANCE INFORMATION**

Who is responsible for this account?: \_\_\_\_\_

Relationship to Patient?: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Is patient covered by additional or secondary insurance?  Yes  No

Subscriber's Name: \_\_\_\_\_

Relationship to Patient?: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

## **ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Back to Health Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or chiropractic office to contact me via mail, email and phone in regards to treatment as well as promotional activities. The above-named clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.**

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Back to Health Wellness Center, PC**  
 2504 Monroe St., LaPorte, IN 46350 (219) 326-5100

**Patient Name:** \_\_\_\_\_

**Identification Number:** \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

**NOTE:** Medicare doesn't pay for Chiropractic Exams, X-rays, Therapies or Rehabilitation when performed by a Chiropractor, below. You may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **Chiropractic Services** below.

<b>Chiropractic Exams, X-rays, and Physical Therapy</b>	<b>Reason Medicare May Not Pay:</b>	<b>Estimated Cost per Treatment:</b>
CPT codes 99201-3, 99212-4	The only Medicare covered service in a chiropractic office is Spinal Manipulation.	\$ 55-105
CPT code 72010		\$ 100
CPT codes 97014, 97012	Medicare does not pay for Chiropractic	\$ 25
CPT codes 97110, 97530, 97112	Examinations, X-rays, Therapies, Extra-	\$ 45
CPT Code 98943	Spinal, Rehabilitation, Supports or supplies.	\$35

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Chiropractic Services** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**(G) OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the **Chiropractic Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the **Chiropractic Services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the **Chiropractic Services** listed above. I understand with this choice **I am not responsible for payment, and I cannot appeal to see if Medicare would pay.**

**Additional Information:** This ABN form will apply for the entire course of Active Treatment and will apply for any progress reevaluations and/or x-rays.

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>Signature:</b> _____	<b>Date:</b> _____
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

# MEDICARE GUIDELINES

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To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated as Medicare rules change.

- **We will file ALL Medicare claims.** (By federal law, we *must* bill Medicare for all services that are covered under the plan, unless you tell us otherwise.)
- We will file **ALL** Medicare Secondary/Supplemental Insurance, if available.
- **We ARE participating providers** with Medicare, which means that Medicare pays us directly. **Medicare patients must meet an annual deductible of \$162**, which we are required to collect at the beginning of services for each calendar year. Supplemental coverage *may* pay the deductible. But if no such coverage is available, **you are responsible for the deductible before Medicare will pay.**
- **Medicare WILL NOT PAY for ALL of your care! Medicare pays for 80% of allowed charges.** Supplemental coverage may pay the other 20%. But if no coverage is available, **you are responsible for the 20% not covered by Medicare.**
- **Medicare does NOT pay for maintenance care.** This will be your responsibility. Maintenance Chiropractic care is important to maintain your improved health status after the symptoms have resolved and maximum improvement is achieved.
- **Medicare does NOT pay for all of your health care costs.** Our recommendations for care are based on the requirements to help you achieve maximum health benefit and are not based on the limits and restrictions of your Medicare coverage or any insurance limitations for that matter.

## **MEDICARE DOES PAY FOR:**

### **1. Chiropractic Adjustments**

- If supported by X-ray and/or examination.
- After deductible is met.
- Depending on the condition.

## **MEDICARE DOES NOT PAY FOR:**

- 1. Examinations**
- 2. X-Rays**
- 3. Physical Therapy**
- 4. Chiropractic Adjustments for Maintenance**
- 5. Products and Supplies**

If you have any questions regarding these guidelines, please ask. We are here to help you!

If you do not like the limits of your Medicare coverage, please contact your government representatives to recommend they expand Chiropractic Medicare coverage.

**I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.**

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Signature of patient or person acting on patient's behalf

---

Date

(A scanned copy of this document shall serve as the original.)

# INFORMED CONSENT for EXAMINATION & TREATMENT

Name: \_\_\_\_\_ Dr.

Case #: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_

Back to Health Wellness Center, 2504 Monroe St., LaPorte, IN 46350

**TO THE PATIENT:** You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedures and/or treatment.

I request and consent to the performance of examination and treatment (chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, rehabilitative exercises and diagnostic X-rays). The chiropractic treatment may be performed by the Doctor(s) of Chiropractic working at Back to Health Wellness Center. Chiropractic treatment and other therapies and procedures may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below as well as those working at the clinic or office who now or in the future treat me while being employed by, working or associated with Back to Health Wellness Center.

I have had adequate opportunity to discuss with the Doctor of Chiropractic, or other clinic personnel, the nature and purpose of my chiropractic treatment (adjustments) and different physical therapy procedures (therapies and active rehabilitation). I have also discussed with Doctor of Chiropractic the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment which includes no treatment at all.

I understand that neither chiropractic, nor any medical treatment for that matter, is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

**I further understand, and I am informed, that there are some risks to chiropractic examination and treatment (adjustments and physical therapy) including, but not limited to: fractures, spinal or disc injuries, strokes, strain/sprains, dislocations, increased or unchanged symptoms and pain; and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.**

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about my examination and treatment, and all my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**FEMALE PATIENTS:** By my initials here \_\_\_\_\_, I do hereby state that to the best of my knowledge, I AM NOT PREGNANT, nor is pregnancy suspected or confirmed at this particular time and. I consent to X-rays if the doctor deems them necessary for the evaluation of my condition. First Day of Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_.

**CONSENT TO EXAMINATION AND TREATMENT OF MINOR:** I hereby agree to the above statements and authorize the doctor(s) of this clinic, and whomever they may designate as their assistants, to administer examination and treatment as they so deem necessary to my:

son  daughter Minor's Name: \_\_\_\_\_

## Patient:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

## Patient's Representative:

Print Name of Patient's Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of Patient's Representative: \_\_\_\_\_ Date Signed: \_\_\_\_\_

## Doctor or Staff:

Witness of Patient's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Translated by: \_\_\_\_\_ Date Signed: \_\_\_\_\_

(A scanned copy of this document shall serve as the original.)



# AGREEMENTS and AUTHORIZATION

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## Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from Back to Health Wellness Center. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by Back to Health Wellness Center. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

\_\_\_\_\_ initial

## Payment Guarantee

In consideration of the services provided by Back to Health Wellness Center, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Back to Health Wellness Center, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Back to Health Wellness Center. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

\_\_\_\_\_ initial

## Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness/preventative care (\$45 per visit), nutritional supplements (\$25-40), therapeutic modalities used for maintenance (\$25), massage (\$35-95) and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

\_\_\_\_\_ initial

## Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that Back to Health Wellness Center do not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

\_\_\_\_\_ initial

## Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Back to Health Wellness Center for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# **AUTHORIZATION and HIPAA PRIVACY NOTICE**

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## **Consent To Release Information**

Here at Back to Health Wellness Center, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Back to Health Wellness Center to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Back to Health Wellness Center for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Back to Health Wellness Center or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Back to Health Wellness Center is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at Back to Health Wellness Center, we strive to provide you with the best care possible and in order to do that this consent is necessary.

\_\_\_\_\_ initial

## **HIPAA Privacy Notice Patient Acknowledgment**

### **For use and/or disclosure of Protected Health information (PHI) to carry out Treatment, Payment and Healthcare Operations**

I hereby state that by signing this Consent I acknowledge and agree as follows:

- 1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
- 2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 3) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at [www.LaPorteWellness.com](http://www.LaPorteWellness.com). I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

\_\_\_\_\_ initial

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(A scanned copy of this document shall serve as the original.)



# OFFICE FINANCIAL POLICY

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*Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with our office staff.*

- No Insurance/Self Pay
- Group Health Insurance
- Managed Care
- HSA/HRA/Flex
- Medicaid
- Medicare
- Secondary Insurance
- Workers' Compensation
- Auto Accident
- Personal Injury
- Maintenance/Wellness Care (Not covered by insurance)

- As a courtesy we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.
- Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We are glad to assist you in billing your insurance, but you are ultimately responsible for full payment. Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. You are considered a cash-based patient until we verify and determine the extent of benefits under your policy.
- Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.
- All payments are due at the time of service. No personal balance is to exceed \$150. We accept cash, checks, and most major credit cards.
- All deductibles and co-payments are due at the time of service or by an authorized payment plan. Most insurance does not cover 100% of services rendered. Because of this and the delay in payment common with insurance carriers, you will be asked to pay your deductible and your portion of your charges the day the service is rendered.
- After 60 days, any outstanding balances will be due in full by you. Balances over 60 days past due will be automatically debited from your checking account or credit card on file or through a third-party vendor. All balances past due 60 days or greater will be charged at a 1.5% monthly (18% annual) interest rate.
- You must inform this office of all insurance changes and referral requirements. In the event the office is not informed or the proper referral was not obtained by you in advance, you will be responsible for any charges denied as a result of not informing us or not obtaining the authorized referral.
- A 50% minimum down payment is required to place an order for products, supplies, orthotics, etc. with the remainder becoming due upon receiving such supplies or products. Full payment is required before receiving any products or supplies.
- Insurance is designed for sick care and only reimburses for services it deems "medically necessary" according to their guidelines. Unfortunately, prevention and health maintenance care is not reimbursable. When your schedule of visits exceeds 3 weeks or if the doctor releases you from active treatment, you will not be eligible for insurance benefits since maintenance/wellness care is a non-covered service.
- Non-compliance with a prescribed treatment plan may jeopardize insurance reimbursement. If you discontinue care or suspend care for any reason other than discharge by the doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claim submitted.
- There is a service fee of \$35 for all returned checks. Your insurance company does not cover this fee.
- Past due accounts (those over 120 days) are subject to collection proceedings, which may affect your credit. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

**Keep this copy for your information.**

# APPOINTMENT POLICY

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*We want to thank you for choosing us as your chiropractic healthcare provider. We understand that your time is as valuable as ours. Because of this, it is our goal to provide to you with our highest quality care in the most cost effective and efficient manner. An understanding of our appointment guidelines is essential for a healthy relationship.*

**Advanced Multiple Appointments:** As you know, healing takes time. Your care will likely require repeated visits as your body progresses through the healing process. As a means of reducing your costs and improving efficiency, advanced multiple appointments are established in order to limit your time in our office by reducing the need to schedule visit-by-visit with the front desk staff. Any deviation from the prescribed treatment schedule may potentially jeopardize insurance reimbursement.

**Rescheduling Appointments:** Please remember that we have reserved appointment times especially for you and that your appointments are “written in pencil”, meaning that it is okay to reschedule if something unexpected arises. Please let us know at least 24 hours in advance of the need to reschedule an appointment. Giving us advance notice will allow time to fill in that appointment with someone else who needs it.

**Cancelling Appointments:** Please let us know at least 24 hours in advance of the need to cancel an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Canceled appointments will be recorded in your medical record.

**Missed Appointments “No-Show”:** An appointment that is missed without at least a 12-hour advance notice to cancel or reschedule is considered a missed appointment. It is the policy of this office to assess a **\$10** missed appointment fee. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. This fee is not reimbursable by any insurance plan. Missed appointments will be recorded in your medical record.

**Extra Visits:** Adhering to your prescribed schedule of care is vitally important to your health recovery process. If you reschedule, cancel or miss any appointment, it is your obligation to complete an extra visit within 7 days in order to not delay your progress.

**Arriving Early:** You are more than welcome to arrive early for any appointment; however, you will be seen by the doctor at your reserved appointment time.

**Arriving Late:** If you arrive more than 10 minutes after your scheduled appointment time you will be worked into the schedule at the next available time slot in order to honor the appointment times of others.

**Open Door Promise:** We understand that life can get busy. So if at any time you get “side-tracked” and decide to put your healthcare on hold, please know that you are always welcome back at any time. Our door is always open to you whenever you decide to start again. Even though it is our duty to educate and encourage you to make the best decisions for your optimal health, we promise to never scold, lecture or yell at you for any decision you make in regards to your own healthcare.

**Keep this copy for your information.**

# **HIPAA PRIVACY NOTICE**

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Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. You understand and agree to allow this office to use your Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so and a cost-based fee for photocopying, postage and preparation may apply.

You may request changes to your records which our practice has the right to accept or deny.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our office is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager, Dr. Kirkham or Kay Engle at 326-5100.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent on the Confidential Patient Case History form.

Thank You.

**Keep this copy for your information.**